DPHHS-QAD/CCL-035
(Revision 07-2006)

Expiration Date _____
Child Care Licensor

STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
QUALITY ASSURANCE DIVISION

RENEWAL APPLICATION FOR REGISTRATION CERTIFICATE INFANT, FAMILY, OR GROUP DAY CARE HOME

Provider Name_____ **Provider Number** _____

Name of Facility_____

Facility Phone # _____ **E-Mail** _____

Facility Address _____
Street City State Zip

Mailing Address_____
Street / PO City State Zip

Directions to day care site (from the nearest major street or highway)_____

_____

Type of registration applying for: [ ] ***Family*** (family homes allow a maximum of 6 children)
(please check one box) [ ] ***Group*** (group homes allow a maximum of 12 children)

*Please specify number of children if you wish to take less than the maximum allowable number of children, as specified above. _____

Number of own children, under the age of 6, that will be cared for at the facility**: _____**

Please mark the youngest and oldest age of children, you wish to provide care to:

0	1	2	3	4	5	6	7	8	9	10	11	12

Hours of operation (days and hours):_____

OVERLAP CARE:
Are you, or do you wish to be, certified for Overlap Care? [ ] Yes [ ] No [ ] Already Approved
If Yes or already approved, Please Answer next question

Are your Overlap Times changing, or is this a new request? [ ] Yes [ ] No **If Yes, Please complete Overlap Form.**

REGISTRY:

Are you a member of the practitioner registry? [ ] Yes [ ] No If so, at what level _____

DAY CARE LOCATION:

Is the day care located in your residence? [ ] Yes [ ] No

If Yes, Please complete both the *Household Members* table and the *Caregivers* table
If No, you only need to complete the *Caregivers* table.

HOUSEHOLD MEMBERS

*In the space provided below please include the name and birth date, of all persons presently living in the home, were day care will be provided. **(Please include yourself, if you reside there)**

Name	Date of Birth	Relationship
1		
2		
3		
4		
5		

CAREGIVERS

Please list the names, addresses, and phone number of all persons responsible for the direct care and supervision of children in your facility and indicate whether they are full or part time. **(Please include yourself)**

PS# (From PS# Card)	NAME	ROLE	WORKS 160 Hrs/Yr	
			More Than	Less Than
1				
2				
3				
4				

a. ***Each person over 18 living in the home and all care givers are required to complete a RELEASE OF INFORMATION Form. ****
   - If a household member or a caregiver has lived outside of Montana within the last five years, that person will need to obtain an out of state background check.

b. ***Each person over 18 living in the home and all care givers are required to complete a STATEMENT OF HEALTH Form. ****

c. ***Each person over 18 living in the home and all care giver, including volunteers, are required to supply copies of their immunizations to the Child Care Licensing Program.***
   Immunizations required are:
   1. ***MMR, if born after 1-1-57***
   2. ***MMR or a Rubella Titer test is required for those born prior to 1-1-57***
   3. ***Tetanus/Diphtheria (required every 10 years)***

d. ***All caregivers must hold a current course completion card in Infant, Child, and Adult CPR (regardless of the ages that are in care) and Standard First Aid***

e. ***Full time employees (those working more than 160 hours in a year) must complete and submit 8 hours of training on an annual basis.***

❖ **The above forms are to be completed by each person over 18 living in the home and all care givers**

In Accordance with the Montana Child Care Act, (52-2-702-714), Montana Code Annotated, I hereby request the re-issuance of a Infant, Family, or Group Day Care Home Certificate of Registration on the basis of my affirmation of the following statements:

Please Initial

_____ a. I have received and have read a copy of the State Regulations for Family and/or Group Day Care Homes and Infant Care.

_____ b. I certify, to the best of my knowledge and belief that, I will be in compliance with the State Regulations for Family/Group Day Care Homes and Infant Care, while children are in care.

_____ c. I understand that I cannot care for more children at any one time than are indicated by the Registration Certificate. This number includes my own children under the age of 6 years.

_____ d. I understand that any complaints about my registered day care home may be investigated by a representative of the Department, without prior notification.

_____ e. I understand that my registered day care home may be visited, and I will allow worker entry.

_____ f. If I move to another address or stop providing care to children I must notify the Department of Public Health and Human Services, Child Care Licensing Program.

_____ g. I understand that the name and address of my registered day care home will appear on a list which is maintained by the Department of Public Health and Human Services

_____ h. I will keep the necessary Insurance in force covering the total number of children I am caring for. I certify that I have adequate Public Liability and Fire Insurance for the purpose of conducting child day care. **Please provide us with the name of your insurance company, the contact person, policy number, effective dates, and number of children, coverage is provided for by completing the "Insurance Verification Form".**

_____ i. I will provide the department with the names, addresses, phone numbers, and parents' names, of each child in my care whenever requested to do so by the department.

_____ j. If you are renting please make sure it is ok with your landlord to provide day care on the rental property.

To the best of my knowledge and belief, all information I have given to the Department of Public Health and Human Services and/or its authorized agents on this form is true and correct. I will supply true and correct information requested during all subsequent contacts.

_____ _____

(Signature) (Date)

TO BE COMPLETED BY A NOTARY PUBLIC:

Taken, Sworn, and subscribed before me, this _____ day of _____ A.D. _____

_____

(Notary Public for the State of Montana)

Residing at _____

My Commission Expires _____